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DOUBLE ANEURISM OF THE AORTA, COMPRESSING AND DESTROYING THE LEFT PRIMARY BRONCHUS, AND CAUSING A PECULIAR AFFECTION OF THE LUNG.

[Read before the Boston Society for Medical Improvement, Sept. 23d, 1861, by **Henry I. Bowditch, M.D.**, and communicated for the Boston Medical and Surgical Journal.]

G. W., a stout-built, American, locomotive engine-driver, I saw, March 19th, 1861. His history was as follows:—Always well, that is, no long illness or accident to prevent work, until four years ago, when he was severely injured in the chest while drawing a locomotive. He was not long confined after this, and soon resumed his usual labor, but he had never been exactly as well as before, and at times there had been a feeling as of a "football" in the epigastric region. For two years this state of things continued, not constant, however, and during all this period he was at work daily as before. Then a hard, dry cough commenced, which had continued to the time of my visit, when it was violent, ineffectual and excessively exhausting to the patient, and distressing to his friends, and without expectoration, except of the most trivial, white, frothy character. A year ago, he had "asthma," so called, obliging him to sleep with the windows open. Of late less of that, but a more permanent dyspnœa. Four months before my visit, he had what was called "lung and typhoid fever" by the attending physicians, since which he had been prevented from all work by an aggravated cough and great dyspnœa, especially on any exertion, and when lying in certain positions. The easiest posture, latterly, had been the sitting one, with the forehead bent over, and resting with his face horizontal upon his hands, supported by a cane. With this state of things came on an œdematous condition of the face, and, to some extent, of the limbs, at times. He had had pains, more or less, in the middle and small of the back. He had not complained of palpitation. His appetite had been poor, but bowels regular. At times there was retching, from the severity of the cough, but never vomiting. The urine had been high colored, with a red sediment, since the fever. He had had no regular hectic, though there was copious sweating after the severe straining paroxysms of cough, and varying like them in frequency, from once every half hour to once in twenty-four hours. At my visit he appeared like a man above the usual size, tall, large, well-formed. His countenance had a puffy, pale look; not anxious, but evidently every breath was a labor to him. The cough was loud, painful from its length and severity, and without relief. It seemed to cease from the fatigue of the patient, often, at times, lasting ten or fifteen minutes, without having accomplished any expectoration. It was not crowing, or precisely hoarse in its tone. The least exertion evidently increased the labor in breathing; speech even increased it. The pulse was 100, regular and small, not evidently different in the two wrists. The tongue was healthy. He complained chiefly of trouble in the left breast. No swelling of feet.

I examined the physical signs on two successive days, and at the last examination Dr. Ellis accompanied me, and made an independent diagnosis. We both came to the following diagnosis and prognosis:—large aneurism of the aorta, about the arch and descending portions, interfering with, and causing the disorganization of, a large part of the left lung. The right lung is healthy, apparently. No evidence of valvular or other lesion of the heart, but dislocation of it outward and downward. Prognosis, death.

Our reasons for these opinions were the above-named rational, and the following physical signs.

Inspection.—A peculiar fulness and rounding out of the whole contour of the neck, seeming as if it were stuffed out. The vessels were manifest, and the larynx and sterno-cleido muscles were not in the least perceptible. The chest likewise was full, but without local prominence, save perhaps in a slight degree about the left clavicular region. The apex of the heart was seen beating low, and under the axilla.

On *percussion*, there was a small space about the aortic region, over the sternum, where there was a slight dulness, but a clear pulmonic sound elsewhere in both breasts. Behind, the percussion was flat at the left of the vertebral column, and to the width of three or four inches from top to base of chest. Clear resonance under axilla, even to base, or nearly so.

Auscultation.—Strong bronchial respiration was heard in the upper third of the left lung, with obscurity of respiration elsewhere, *even in parts resonant.* At the first examination there were loud "consonating" râles where bronchial respiration was heard in front, and they were caused by the motions of the heart being synchronous with the movements of that organ. They were not heard subsequently, at two examinations.

Cardiac and Aortic Physical Signs.—No *marked* prominence about aortic region, but the heart was seen pulsating two or three inches outside and below the usual spot. Its impulse and sounds were not unusual. But over the aortic region was an impulse, evident, with a strong bellows-murmur. This murmur was heard very strongly in the left back. There were no morbid sounds over the right lung, front or back, save puerile respiration, and the transmitted aortic bellows-murmur.

A preparation containing digitalis, colchicum seeds and acetate of morphia was given as a placebo, and with the faint hope of giving a slight ease from the constant dyspnœa. Tincture of gentian, as a stomachic, was also allowed.

On March 24th, i. e. three days subsequently, I saw him again. He had been easier, and had been able to lie on the right side. Could not easily sit erect, or attempt to lean forward without severe pain seizing him all around the waist, for a space about three inches in width. The cough had been severe, and he had raised, for the first time, a little blood.

From this he continued about the same, until April 2d, i. e. nine days subsequently to my last visit. On this day he had a sudden copious hæmorrhage, estimated at one or two pints, under which he fainted. Eleven days afterwards, another hæmorrhage, still larger, occurred, and he was found weltering in his blood, and *in articulo mortis.*

Autopsy by Dr. ELLIS, about twenty-four hours subsequently. Body large and pallid. Much œdema of the cellular tissue everywhere. From four to six ounces of serum in the pericardium. The heart was pale, but normal. The first inch and a half or two inches of the aorta were dilated in such a manner that shallow pouches were formed. The next five inches were largely dilated, the vessel here measuring nine inches in circumference. Within, were layers of fibrin, with a maximum thickness of one inch, but gradually blending with the lining membrane, with some smaller and thinner deposits of the same character. Beyond this dilated portion, the vessel was about the usual size, and continued so for an inch, when it again dilated, forming another pouch, about two inches in diameter and an inch in deph. Both of these had compressed, and finally opened into, the left primary bronchus, of which a portion, an inch and a quarter in length, and involving nearly the whole circumference, was destroyed. The edges of the opening were very irregular; and the base was formed by the light-colored coagulum previously described. The communication with the smaller aneurism was established by a small opening near the other. A portion of the surface, from a quarter to half an inch in diameter, of one of the secondary bronchi, was also deeply ulcerated, but not by the immediate action of the aneurism. There was a marked depression in the vertebral column behind the enlarged vessel, presenting the usual appearances of eroded bone.

The left lung was not seen on raising the sternum. The pleural surfaces were firmly united by thick false membrane, rough over a portion of the surface, and not very dense, but at the apex and posterior part very thick, firm and fibrous. At the apex it formed the walls of a cavity upwards of an inch and a half in diameter, filled with serum, and lined by a delicate reticulated membrane. The lung was eight inches long, and four wide. It was generally of a dark-gray color, and quite dense, though some parts contained air, but not enough to cause crepitation. The elasticity was most marked on the side and back. Scattered throughout its substance were irregular, dull-yellow portions, of all sizes, from that of a mere point to that of a pea. At the time of the examination, there were apparently many small cavities filled with pus, but after thoroughly washing the part these were not so obvious. The appearances, however, were unquestionably owing to inflammation. The bronchia and bloodvessels were everywhere seen upon the cut surface. The former were filled with a bloody fluid. The inner surface of the smaller bronchia was covered with a thick yellow material, partly composed of degenerated epithelium. It was about the extremities of some of these that the lung appeared to be particularly diseased.

The vessels seen did not contain coagula, and were in appearance healthy. The same was true in regard to the branches arising from the arch of the aorta. The bronchi were full of bloody fluid.

The right lung was enormously hypertrophied, and did not collapse, either when removed from the chest or after incision, small portions, even, showing this peculiarity. It was elastic, and crepitated throughout.

Scattered throughout the lung were numerous, small, deeply-injected spots, which contrasted strongly with the adjacent tissue.

The spleen was large and dark; the kidneys were dark, but normal; the intestines appeared well.

Remarks on the Case.—It had been deemed a very obscure one up to the time of my visit. Yet on a thorough examination of the symptoms and of the physical signs of the lungs and heart, it seemed impossible to make any other diagnosis than that to which we arrived

Dr. Ellis was materially aided in making up his mind by a series of similar cases reported by him in this JOURNAL, Dec. 4th and 11th, 1856, and to which I would call attention. They prove that "inflammation and abscesses of the lung" may occur, when from any cause a primary bronchus is obstructed.

DR. WARE'S LECTURES ON GENERAL THERAPEUTICS.

LECTURE IX.—(Concluded fsom page 309.)

IN chronic diseases, though the essential principle upon which the regulation of the diet is to be managed is the same as in acute, yet the greater variety of the conditions they present render its regulation more complicated. First of all, the selection of the food and its quantity depends upon a regard to the appetite of the patient and the disposition which the digestive organs are capable of making of it; but beyond this it is also necessary to consider the relation which the quality of the food bears to the nature of the disease, and to the influence it may exert as a remedial measure. These topics can only be very superficially treated of, and we must confine ourselves rather to indicating the course to be pursued in the study of diet in its relation to disease, than attempt a complete exposition of the details of its management.

The appetite and the state of digestion are obviously the first things to be looked to as our guides to the diet, and yet it is equally obvious that they are not alone sufficient guides, but must be subject to many qualifications. Considered by themselves alone, we find them presenting the following varieties:—

1. The appetite and the digestion may be both good, or in a natural condition.
2. The appetite good and the digestion bad.
3. The appetite bad and the digestion good.
4. The appetite and the digestion both bad.

The terms are here used in their usual and most comprehensive sense. We call the appetite good, when it does not notably depart from the healthy standard, and it admits of all degrees of departure from this, both as to kind and quantity, down to a point in which it is absolutely absent and attended by an actual repugnance to food, or even by nausea. We call digestion good, when the function, considered in its whole extent, is healthfully performed, and it departs from this in various degrees, till no operation is performed on the food, but it is either rejected or passed through the canal without any effort at assimilation. It is obvious that here is an opportunity for unlimited variations in both respects. The appetite may be good for vegetable food and bad for animal food—good for liquid and not for solid—good for sweets and not for acids. The power of digestion may present similar differences. It is manifest therefore that, although these are necessary points of attention, in studying the appropriate diet in any case, they still include under them a great many other particulars which require consideration. Thus the patient may have a sufficient desire for some particular kinds of food, but not for those which are appropriate to his disease or to his capacity for digestion; or it may be, as to quantity, far beyond his power of digestion; and so his capacity for digestion may be good as to certain kinds of food, but not for those which he most desires; these may be such, that if they are taken, they inevitably derange his stomach, or disturb his bowels. For example, in the capricious state in which patients are often found, simple food like bread, milk, rice or meat, may be disliked, and yet if taken, be borne and digested perfectly well, whilst the preference is for gravies, rich soups and puddings, pastry, preserves, cakes, &c.—which, if taken, are likely to do injury.

These particulars present infinite difficulties of judgment, and require in each case a careful and repeated study of these two relations of appetite and digestion, and of the proper correspondence between them. It is to be kept in mind, also, that this relation is liable to undergo constant changes. It may be that these changes are frequent and abrupt; that the food which is relished to-day will be loathed to-morrow, or that which agrees well to-day may oppress to-morrow. More frequently it happens that a course of diet which has proved suitable for a considerable period, will, without any change of symptom or in the character of the disease, become unsuitable.

As a general principle of judgment the appetite is to be always first consulted. What is best relished is apt to be best digested, or at any rate, that which is taken without relish is very apt not to be well digested. Still this is very far from being a rule capable of universal application. The exceptions are almost innumerable. But it is more common to have the appetite suggest that food which the stomach can digest well, than to have it digest well that at which the appetite revolts. This is so much the case that it is seldom proper, for any length of time, to insist rigidly upon a course of diet which is offensive or even distasteful to the patient. Yet this is sometimes necessary, and is particularly likely to be found so in those who have been addicted to good eating as a special enjoyment—have accustomed themselves to food delicate in kind and cookery, and have consequently become self-indulgent and fastidious as to taste and seasoning. In such persons are found some of the hardest cases to manage. Feeding has become a matter exclusively of indulgence of the palate, without any regard to the relations of food as nourishment, and unfortunately the direct evil effects of the articles to which they are addicted do not take away the relish for them, as often happens with regard to simpler food. Hence we have to contend with a vicious sensual habit, and, at the same time, a perverted habit of mind. These are the patients in whom the relish for food can hardly be at all consulted. It is often necessary to confine them to that which is absolutely disagreeable, and to subject them to a species of discipline of the digestive organs, under which alone they can return to a healthy condition. Under such discipline they may for a time lose both flesh and strength, but in the end a natural appetite becomes restored.

Beginning with a reference to this correspondence between appetite and digestion, and keeping also steadily in view the effects of all food, and its relation, both as to kind and quantity, to the nature of the disease, a variety of other particulars require attention in the adaptation of diet to each case.

There are some cases in which the processes of disease going on are not of an exhausting character; there is little consumption of the material of the system—there is little suffering or pain—no loss of sleep—no disturbance of the mind or nervous system, and but little if any increase in the activity or rapidity of the circulation and respiration. Commonly the ordinary nutrition is diminished, and there is less appetite and capacity for digestion; but this is not always so, so that there sometimes is and sometimes is not, a degree of emaciation and diminished strength. Examples of this kind are found in the early stages of some malignant cases—of slow tubercular disease—of hypertrophy, and of many others. In such, a smaller quantity of nutriment may be sufficient, than in health; the kind to be selected by a reference to the relish of the patient and to the phenomena of digestion. The quantity, however, is not to be diminished below the healthy standard, at the risk of reducing strength. The true amount is that which is most perfectly assimilated. In health a quantity beyond the demands of the system may be taken with comparative impunity, and nutriment imperfectly assimilated may be introduced into the mass of blood and disposed of without injury. In disease this is less likely to be so, and the presence of an imperfect material tends to aggravate the disease.

There are some cases of a peculiar and rather mysterious character—not organic in their nature—in which there are many irritating symptoms—very imperfect sleep—a capricious and variable appetite and a loss of strength, yet in which the nutrition, so far as bulk is concerned, is well preserved; the countenance is healthy, and the appearance of health is maintained, though the patient complains of much suffering of various kinds. These cases are usually called nervous or imaginary, and are often hardly judged and get little pity. There is no doubt, however, that the sufferings are real, though aggravated by the state of mind and the apprehensions of the patient. These cases are usually connected with hysteria and obscure functional affections of the womb, but cases closely analogous, though infrequently, do occur among men. The kind of food must be determined by the observation of each individual, but the quantity should be usually less than that which the appetite calls for—less than that which is taken in health, but of a nutritious and rather stimulating character.

A very different class of cases from both these, is where an exhausting and reducing process is going on, as where there is either a great consumption of material—a very active circulation and respiration—a great deal of pain, irritation and suffering of various kinds—and a loss of sleep. Of this class are large discharges of pus—pulmonary consumption, and scrofulous diseases of the joints, with hectic fever—the late stages of cancer, diabetes, dropsy, and many others. Here, when the appetite and digestion are good, a free, nourishing and stimulating diet is to be allowed; and where they are not good, a principal object is to restore them if possible by tonics, stimulants, and a constant supervision of the hygienic condition in all respects. Everything in the way of changes and delicacy of food, abundant exposure to air abroad and change of place, are to be had recourse to in order to solicit the return of the powers of the digestive organs. The rapidity of progress in such cases, particularly in those which are necessarily fatal, is very much modified by the state of the digestive organs in this respect. As long as the appetite is good, and the capacity for assimilating as well as taking food remains, the progress may be slow and life protracted a long time, even with a great amount of disease, whilst, in the opposite state of things, the decline will be speedy.

We observe in some forms of chronic disease, that the appetite is sufficient, perhaps greater than that of health; digestion, so far as we can judge, well performed; there is no obvious exhausting or irritating process going on, and yet the patient gains neither flesh nor strength, but, on the contrary, becomes daily weaker and regularly emaciates. This is indicative of a very unfavorable condition, usually of the existence of some irremediable organic disease, either latent, or else of such a character as not to disclose by any of its obvious traits the circumstance upon which this failure of flesh and strength depend. Organic disease of the brain, such as softening, and malignant disease in the abdomen, furnish the most frequent examples of this; but there are some cases which prove fatal in which no disease whatever is found, and others, especially in young persons, where ultimately recovery spontaneously takes place. It is difficult to determine here what becomes of the nutriment which is apparently assimilated and absorbed. Perhaps, as one of the obscure results of the disease, nutrition is prevented, or the assimilation stops short of that degree of completeness which renders its results suitable for application to the purposes of life, and they are carried off by the excretions without any such application.

Probably a large proportion of those chronic affections usually denominated functional—that is, which are not accompanied by any permanent organic change—are connected with something imperfect, or something vicious in assimilation, in consequence of which the nutritive processes are disturbed and abnormal. Whether this depends wholly upon the state of the blood, or upon the application of the blood to its purposes, it is impossible to determine, perhaps upon both. The influences combined are various and complicated, and they must be met by measures that are equally so. Among them the regulation of the diet, and of those causes by which the digesting and assimilating organs are governed, are among the most important. This is most strikingly illustrated in the history of scurvy, where their influence in the production of the disease, and also in its removal, has been so often noticed. This is undoubtedly the most distinct and forcible example of the kind, but it is reasonable to believe that analogous though less clearly cognizable results may follow from other deviations from a healthful mode of living, and may be removed by a corresponding regulation of the habits of life.

In all chronic affections the relation of the diet to the assimilation is a consideration to be always kept in mind. We are to regard not merely the relation of food to the primary digestive organs and their immediate and direct disturbance, but further the way in which its quality and the changes it may undergo in the course of its assimilation may affect the character of the nutrition in all parts. We are too apt to confine our attention to the immediate influence of different articles of food upon the stomach itself and the alimentary canal; and to the effects which these organs may have on other parts from sympathy with their disturbed condition. But these effects, though immediate, are comparatively transient, whilst it is probable that the other effects adverted to, though less obvious, are more permanent and difficult to remove.

The following remarks of Dr. Prout in regard to one particular form of aliment, the oleaginous, are of much significance, and are to be considered not only in relation to this form, but as also capable of application to the whole subject of the connection of the state of the nutrition with disease and of the influence which food may have upon it. " This subject," he observes (the pathology of the oleaginous principle), " in many points of view, is one of great importance; as I am satisfied, from long attention to the matter, that the oleaginous principle is much more deeply implicated, not only in the operations of organic life, but in those higher operations connected with the animal functions, than is commonly supposed. If such be the case, its pathology must be commensurate; and I venture to foretell that this will hereafter prove to be the case; and that some of the most formidable diseases to which animal existence is liable, will be found to be connected with, or to result from, the mal-assimilation of the oleaginous principle."

Remarks coming from so careful and dispassionate an observer, and drawn from so wide and experienced an observation, deserve to be carefully considered. They are eminently suggestive, and are capable of application to the whole subject before us. Other alimentary principles besides fat, may by their mal-assimilation, according to the constitution of different individuals, and also according to the different forms and qualities which the same alimentary principle may assume when coming from different sources, play an important part in the production and course of disease, and also upon the symptoms which are from time to time exhibited. The study of diet, therefore, in relation to disease, may be greatly assisted, and the successful arrangement of it be promoted by attending to such suggestions.

The efficacy of certain remedial measures having sometimes a decided influence in changing the whole character and course of disease, is probably founded upon a power they possess of correcting the mal-assimilation of some of the elementary principles of food, or of giving a new direction to some of the processes of nutrition. Examples of this sort may be found in the effects of cod-liver oil, of the vegetable acids, especially lemon-juice in large quantities, the free use of fruit, of wine, of mineral waters, and of iodine.

The affections connected with an imperfect or vicious assimilation, either as cause or effect, are among the most important chronic maladies which become the subjects of treatment, because they may ultimate in organic disease if not arrested; and also because they may continue many years, without any such tendency, and, unless they do, there is always a prospect of their removal by such means as will promote the natural tendency to recovery. It may also be remarked of them that there seems to be in many constitutions a spontaneous revolution which in time effects their removal, probably by a change in the mode of nutrition of which we can give no account. Thus, in consequence of such a revolution, many aggravated and inveterate cases of dyspepsia, which have afflicted patients for years, cease gradually when they pass the middle of life; and, more especially, headaches under which they have labored from youth upward, disappear on the approach of age. The most marked examples, however, of such spontaneous revolutions of the constitution are to be noticed in children. It often happens that those which have been previously either simply of feeble health, or else subject to croupal and other complaints of the throat, and to frequent or constant affections of the lungs and digestive organs, undergo an entire change in all these respects, and become comparatively healthy. Something of the same kind, though less frequently and to a less degree, may be observed at a subsequent period in connection with the development of the sexual distinction.

It is to be recollected that no regulation of the diet alone, is sufficient in all cases to ensure a perfect state of the assimilation, without attention to other precautionary hygienic measures. It often happens that a well arranged system of diet, strictly carried out, is utterly inefficacious, whilst a change of residence, of climate, of occupation, of habits of life, is at once successful; and so, too, we sometimes find that a similar change will prove effectual, in spite of a total disregard of all the dictates of prudence as to the selection of food.

Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY FRANCIS MINOT, M.D., SECRETARY.

Oct. 28th. *Internal Strangulation of a Loop of the Small Intestine.*—Dr. Ellis showed the specimen, which was sent him by the attending physician. It was taken from a man, 23 years of age. Three years before his death he had what was considered colic, which was followed by typhoid fever. After a confinement of four weeks, he slowly recovered, but for four months he was unable to attend to his usual business, which was painting. He then turned his attention to paper-hanging, and enjoyed pretty good health until September 25th, when he was attacked with severe pain in the umbilical region. Castor oil was given, and also an injection; the latter only operated. On the following day he vomited the oil. Twelve grains of calomel and rhubard were then given, in doses of two grains. These were rejected in the evening, and afterwards a large quantity of fluid, containing a green, flocculent material. An injection of senna was then given, but passed off without any fæcal odor. On the following morning, senna and salts were administered, without the desired effect. The next day he was seen by another physician, who advised croton and castor oils. These were rejected. Three days afterwards he was seen by a third physician, who advised two drops of croton oil every four hours, until twelve drops were taken. This was rejected, and the matters vomited had a fæcal odor. From that time he vomited large quantities of fluid two or three times daily, although what he took would sometimes be retained six or eight hours. Enemata seemed to soothe him. Brandy and whiskey were given, and local applications made. The pain was always in the umbilical region, but of no great severity. He complained rather of a distressed feeling. No tenderness on pressure. During the first week there was fever and a red tongue. The pulse, on the first day, rose to 130, but afterwards fell to 104. The countenance was good, and he seemed to die of exhaustion, seventeen days after the commencement of the attack.

The intestine was the only part seen by Dr. Ellis. The different portions were everywhere united by old delicate false membranes, which it was found necessary to separate before the condition of the parts could be ascertained. It was then found that a loop of the small intestine, four or five inches in length, by estimate, and fifty-one inches from the cœcum, was of a blackish color, and constricted at the two extremities. Considerable distension of the intestine above. Near the lower constricted point were a few small, sharply-defined, superficial ulcers, perhaps a line in diameter. No other trace of recent inflammation, either external or internal.

Dr. Bowditch protested against the use of active cathartics in obstruction of the bowels where there is any suspicion of strangulation. The pain should be relieved by opiates, leeches should be applied to any spot where there is tenderness, and the strength of the patient should be supported by concentrated nourishment.

Dr. Jackson said that he had examined, *post mortem*, many of these cases of "stoppage of the bowels," so called, and the treatment in a large proportion of them had been one and the same—cathartics, commencing with the mild, and ending off with the most drastic, sometimes only at the death of the patient. Nothing seemed to be thought of the condition of the organs; the constipation was the one sole object. There are so many conditions, he remarked, in which this one symptom should not be so attacked, that it would seem to be wiser to pursue a palliative course in an obscure case, and where the symptom in question resisted ordinary means—presuming that one of these conditions might perhaps exist. Internal strangulation may often be overlooked by the best observers; but there are cases in which the diagnosis is sufficiently clear, and in such there would certainly be but one course to pursue. The fact that the patient has had similar attacks previously, is in itself one of the indications of strangulation. The mechanical cause has existed, perhaps, for years, and the intestine may have been often partially strangulated, as in external hernia; the intestine withdrawing itself if not irritated. Dr. J. has often found the stricture perfectly tight, so that no active treatment could have relieved it but the knife; but, on the other hand, he had often found the intestine lying perfectly loose in the sort of ring through which it had passed, and so that it readily withdrew itself when the parts were held up. He had formerly heard Dr. James Jackson speak of a very interesting case that he once saw in consultation; in addition to the other signs of internal strangulation, there was a tumor in the abdomen; the patient was being treated, as usual, by cathartics, and Dr. J. used every endeavor to stop this fatal course; he succeeded, and the result was perfectly successful; the tumor gradually subsided, and with the relief to the symptoms there came the free alvine discharges that so often follow the operation for external hernia.

Dr. **Fifield** said it was not always possible to bring philosophy to bear on these cases. The diagnosis of internal strangulation is not always easy, and it is certain that some cases *are* relieved by laxative treatment. The patient and his friends, knowing that he would be relieved by a movement of the bowels, will not be convinced by arguments or statistics, and the physician is sometimes forced to adopt a line of treatment which is perhaps contrary to his judgment.

Dr. **Coale** had found enemata of assafœtida and the inhalation of ether of service in these cases.

Dr. **Warren** said he had had patients go from ten to fourteen days without evacuating the bowels, after an operation for lacerated perinæum, for example, who did not suffer the least inconvenience from it. He considered cathartics in cases of strangulation as injurious. He generally gave ether first, by inhalation, to relieve the pain, and then opiates; these assisted by local applications. In cases of stoppage, with tumor in the cœcal region, if no organic affection, this method had succeeded in producing a natural discharge. A mild laxative, or an enema, perhaps, may be used after all irritation has subsided.

Dr. H. K. **Oliver** had kept a patient constipated for twenty-one days, after an operation for lacerated perinæum, without any discomfort to her.

Dr. **Ellis** remarked that the cause of death, in internal strangulation, is very mysterious. It is not owing to inflammation or rupture. There was no peritonitis in this case. The strength of the patient seems to sink under the effort to overcome an invincible obstacle.

Dr. **Jackson** said he had never seen peritonitis in any case of internal strangulation, however long it had existed.

Nov. 11th. *Injury of the Axis, with Separation, Displacement and subsequent Anchylosis of a large Portion of it with the third Vertebra.*—Dr. J. Wyman exhibited the first four cervical vertebræ from the human body, the second, third and fourth of which were anchylosed with each other; and in addition, the following abnormal conditions existed. A part of the body of the axis, with the odontoid process, the whole of the articulating surface on the left side, and a large portion of that on the right, had been detached from the arch, carried forward, depressed obliquely in front of the third vertebra and anchylosed with it. The line of separation, though obscured by subsequent changes in the surface of the bone, appears to have been obliquely from above downward and forward, through the body of the bone, through the left pedicle, just behind the foramen for the vertebral artery, and on the right side through the hinder part of the articulating process, leaving the foramen for the vertebral artery in connection with the arch behind it. The base of the odontoid process was in front of, and on a level with, the body of the third vertebra. The body of the axis, when seen in front, has its natural texture, but is continued downward by a thick accidental ossific deposit in front of the fourth vertebra, which last is mostly concealed by it. The arch of the axis remains in its natural position, and is anchylosed with the third vertebra by means of its articulating processes. The space corresponding with the intervertebral foramen is bridged over by adventitious bone. Behind the odontoid process the remaining portion of the obliquely truncated body of the axis is seen in its natural position. The foramen for the vertebral artery in the axis, on the left side, instead of being just above that of the next vertebra below, is in front of it, but is in its natural position on the right.

The atlas presents several abnormal conditions; its upper articulating surface on the left is polished from direct contact with the condyles of the occiput; the arch is not closed up posteriorly, and is considerably roughened at this part, as if from the effects of disease; on the under edge of the arch there exists on each side an accidental articulating surface, corresponding with similar ones on the upper edge of the axis, where the two bones have rubbed on each other. These false articulating surfaces are in the direct line of the true ones below. When placed upon the axis, the atlas is in advance of its natural position, in consequence of the odontoid process having been carried forward, and its arch, instead of being just above that of the axis, overhangs the middle of the spinal canal, and thus very materially diminishes the diameter of it. Sufficient space, however, is left to lodge the spinal cord without compression, but not enough to admit of much freedom of motion.

These bones were taken from a dissecting-room subject, and nothing is known of the history of the case. The complete union of the different parts, and the absence of any indication of active disease, show that the injury occurred at a long period before death. There was nothing in the general appearance of the bones to show whether displacement took place suddenly, from the effects of an accident, or was the result of prolonged diseased action.

Cases more or less resembling the above have been reported by different observers, and among them the following:—

Description of a specimen of dislocation of the atlas upon the vertebra odontata, attended with contraction and distortion of the vertebral canal, by Alexander Shaw. (Med.-Chir. Trans., Vol. XXXI., p. 289.)

An account of a dislocation consequent on disease of the first and second cervical vertebræ. (Med.-Chir. Trans., Vol. XXXI., p. 285.)

On Dislocation of Vertebræ, by William Lawrence. (Med.-Chir. Trans., Vol. XIII., p. 387.)

Bibliographical Notices.

On the Parasitic Affections of the Skin. By T. M'CALL ANDERSON, M.D., Fellow of the Faculty of Physicians and Surgeons, Physician to the Dispensary for Skin Diseases, Physician to the Deaf and Dumb Institution, Glasgow, &c. London: John Churchill. 1861. 8vo. Pp. 152.

THIS comprehensive little treatise on one of the most important classes of skin diseases first appeared in a series of articles published in the *Medical Times and Gazette.* The author has wisely brought them together in the volume before us, with several additions and corrections, and has, in so doing, made an extremely valuable contribution to the literature of this subject. The cutaneous affections due to the presence of a vegetable parasite are first considered These are divided into four classes, viz.: *favus; tinea tonsurans,* which comprises three varieties; *alopecia areata;* and *pityriasis versicolor.* The cutaneous affections owing to an animal parasite constitute the second portion of the work. The book is illustrated with wood cuts, and its whole appearance is elegant and attractive, as it should be when we consider the somewhat unattractive nature of the subject. We can conscientiously commend it to the profession for the clearness and accuracy with which the author has treated his subject.

Medical Jurisprudence. By ALFRED SWAINE TAYLOR, M.D., F.R.S., Fellow of the Royal College of Physicians, Hon. M.D. Univ. St. Andrews, Member of the Royal College of Surgeons, and Professor of Medical Jurisprudence and Chemistry in Guy's Hospital. Fifth American from the Seventh and revised London Edition. Edited, with additions, by EDWARD HARTSHORNE, M.D., one of the Surgeons of the Pennsylvania Hospital. Philadelphia: Blanchard & Lea. 1861. 8vo. Pp. 714.

WE have before noticed this work at some length, and have only to say now that the present edition has been carefully revised by the author, and contains the latest results of legal and scientific investigations. It is rare that a medical work issues from the press which is of such general utility as this of Dr. Taylor, and from present appearances it seems destined to maintain its high position as a leading treatise on the subject of Medical Jurisprudence. No medical library is complete without it.

Army Medical Intelligence.

[From our Special Correspondent.]

Messrs. Editors,—My series of histories of cases at the United States General Hospital in this city must, for a brief period at least, cease. Since my last communication a sad catastrophe has befallen us. A week ago night before last the Hospital building was discovered to be on fire. The miserably deficient fire department were unable to quell the flames before complete ruin was the result. The scene for nearly two hours was almost indescribable. The agonizing shrieks of the patients, the hurrying to and fro of the sick and suffering, the readiness and eagerness to help of the medical officers, the kindness and true Christianity of the Sisters of Charity, the humanity of all, are painted on my mind never to be effaced. Nor can I forget for a moment the hearty coöperation the patients gave. Though they suffered much, they complained not, and those who were able lent a helping hand to the more needy. The Sisters of Charity, who had the care of the Hospital prior to its destruction, lost everything they possessed, but with patience and true humanity they tried all night and day to relieve the suffering and the helpless. The patients were all saved except one—an old female, who, though able to walk, was in her second childhood. As I write, her bones are being picked up among the pile of ruins. Dr. White, the Superintendent, lost everything, amounting nearly to $1,500 in value. Dr. Gouley lost nearly $500 worth, and Dr. Pooley a small amount. Drs. Bodman, Hutchins and Allen, Medical Cadets, lost everything they possessed, and barely escaped with their lives. The patients suffered comparatively nothing from the shock. The convalescents were moved to the other military hospitals, while the more serious cases are still under the same officers in a school-house adjoining the premises.

The loss of such a building at this time is felt by all; it was the model Hospital, in every respect, of the whole army of the Potomac. There will doubtless be another established, but when and where, I am unable to say.

You shall hear from me again ere long. H.

Washington, D. C., November 14, 1861.

The following is an extract from a letter giving some account of the present condition of the troops recently engaged at Ball's Bluff.

To the Surgeon General. Worcester, Monday, Nov. 11, 1861.

Dear Sir,—I reached home on Friday last, and as I was at the seat of war in a semi-official manner, with your sanction, it seems to me proper that I should report to you.

I was not able to get away from home so early as I had expected to, and went directly to Poolesville, Maryland, arriving there Wednesday, Oct. 30th. I remained till Friday, Nov. 1st—seeing all the sick and wounded men in Col. Devens's regiment, and some of them several times, besides some of the wounded men of other regiments. All seemed to be very well taken care of, and most to be doing very well; so that only three or four of those then wounded or sick, in all more than one hundred, would probably die.

Dr. Bates was recovering from his illness, though still far from well.

He had got up from his sick-bed on the day of the battle, to render his assistance on Harrison's Island, and had done a large day's work that day and every day after, though needing as much care himself as many of those whom he was taking care of. Dr. Haven was also rendering excellent service, and had been very assiduously employed since the battle. The Brigade Surgeon, Dr. Crosby, of NewHampshire, was doing excellent work. I do not know that it is proper for me to call the names of persons in this manner, but, if it is not, my report is only semi-official as my visit was.

I was very much pleased with the temporary Hospitals erected at Poolesville. The ventilation of these was excellent, and the whole arrangement contributed very much to the comfort and welfare of the patients, as well as to the convenience of the Surgeons and the attendants. Miss Stevenson, of Boston, had arrived the same day that I did, and her services were represented to me as being grateful and valuable.

I did not "inspect" the sanitary condition of any of the other Regiments in that neighborhood.

On Monday, Nov. 4th, my movements having been somewhat retarded by the violent storm of the 2d, I visited some of the Regiments on the Virginia side, in the vicinity of Hall's Hill, with Dr. Lyman, of Boston, Brigade Surgeon and medical director in that vicinity. The sanitary condition of his men was excellent and improving, as may be seen at a glance by the following figures:—

Oct. 1*st.*—Whole force, 2,882. Under treatment during month previous, 692. Remaining sick, 137; convalescent, 37—174.

Nov. 1*st.*—Whole force, 3,944. Under treatment month previous, 739. Remaining sick, 61; convalescent, 30—91.

So that while on the first of October one in every 16, or about six per cent, were sick, on the first of November only one in 43, or about 2 1-3 per cent, were sick. In reckoning the number under treatment, during the month, I need not remind you that the whole number advised for, be the cause ever so slight, is reckoned. These results are very gratifying in view of the higher office of the physician.

I went over the Potomac only once, the broken weather and the broken long bridge being serious obstructions to any pleasant or useful inspection. I am most respectfully,

Yours very truly, J. S.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON: THURSDAY, NOVEMBER 21, 1861.

Fee Bills.—We received, some time since, the following communication, but have not had space to print it nor the opportunity to answer it until now:—

Messrs. Editors,—Can you inform me why it is that medical journalists seem to studiously avoid the publication of the fee bills of their respective cities? Is it a crime to do so? Or is it unprofessional? Or is it that they do it purposely, to enhance the difficulty of physicians in collecting their accounts, by leaving them without any list of regular charges to which to refer?

Every physician knows how frequently the charge of exorbitancy is made against doctors' bills, and one would suppose that a medical editor might know how desirable it therefore becomes to have the regular list of professional charges as familiar as possible to everybody. Notwithstanding this, I have to-day ran through somewhat over 100 volumes of medical journals, some 30 of them being the *Boston Medical and Surgical*, and yet have failed to find a single fee bill in any! They refer very frequently to fees and fee bills; so that they are not ignorant of the existence of such things. Nay, they discuss the matter as if everybody must be *familiar* with the fee bills to which they refer; but, even where they notice radical changes in those bills, they carefully avoid mentioning to what extent, or dropping even a single inadvertent word by which any one might have the least chance of judging of the contents of those fee bills! This, so far as I can judge of the matter, answers only one purpose, and that is the one already suggested:—it leaves physicians without any authority to which they shall refer their debtors, lawyers, or jurors, in proof of the justness and moderation of the charges in their medical bills. It therefore leaves them to have their accounts reduced, by arbitrators, boards of unscrupulous county officers, or the like, to whatever the prejudices or littleness of such persons may dictate.

I suppose that the physicians of Boston *have* a fee bill, and I presume that they would not regard its publication as an infringement of their copyright, or even as an over officious interference with their private business. Would it be asking too much of the *present* Editors of the *Boston Medical and Surgical Journal* to request them to make the hazardous and hitherto untried experiment of publishing the said fee bill in their JOURNAL, for the information of their readers out here on the borders of civilization? Perhaps it might, at the same time, be a very acceptable morsel to some readers nearer home. GEO. B. WILLSON.

Port Huron, Mich., October 11th, 1861.

The writer of the above is evidently smarting under a personal experience of the annoyances which so often disgust an honorable and benevolent physician in arranging the matter of compensation for his labors. The animus of the profession, we think we may say without presumption, is strongly repugnant to measuring by dollars and cents the value of the service rendered in any case involving responsibility or anxiety on the part of the practitioner. We all know that there are occasions when, under Providence, the hand of the physician holds the balance between life and death. In other instances, the responsibility and the anxiety may be even more burdensome, yet a fatal event may, to many unprofessional minds, detract very largely from the merit of the physician, and make his hard-earned fee the ungracious and grudging tribute from a reluctant hand. All physicians of any experience, we presume, have felt this; it is one of the inevitable trials we must expect to meet. A short time since, in pressing the payment of a small bill upon the relict of a poor fellow, whose last days we had endeavored to make comfortable in his sufferings from the dropsy of albuminuria, we were met by sour looks and the insulting reply that we had continued our attendance for some time after we knew the patient could not recover! Comment on such indecency is unnecessary. We must all, however, swallow our pride as best we may, for fees are necessary and fee tables very important. Our correspondent is unreasonably irritated, we think, at failing to find any published fee lists in the Medical Journals. The simple answer to his question is, that each medical community has its own standard of charges, which is known to the members of that community, and beyond it is of little interest to the profession. Such is the case here, where the fee table is regulated by the Boston Medical Association, an Association to which every member of the Massachusetts Medical Society is entitled to be admitted. The fee table of the Association has been arranged with great care and deliberation, having been modified from time to time to meet the changing circumstances of the community, and now covers nearly two pages of the Rules and Regulations of the Society, comprising thirty-nine different items. We have not space to reprint the whole, but give some of the principal charges for the information of our correspondent, and any others who may be curious on the subject. It will be seen that a sliding scale has been adopted, and even this is not strictly limited to the charges upon it, as is shown by the following extract from the remarks preliminary to the Rules and Regulations. It is plainly impossible to fix anything more than a proximate standard of charges.

> "In the present table, there is named for each service the limits within which the fee shall be placed, though not designing to prohibit a higher charge where the time devoted, or the importance of the service rendered, should call for it; nor, on the other hand, to forbid a deduction to those in limited circumstances, in proportion to the exigencies of the case."

From the fee table we take the following items:—

For a visit	$1.00 to 2.00
For a visit and first consultation	5.00
For a visit and each subsequent do., if the attendance be continuous	3.00
For a visit out of town,* for every mile from the centre of Boston	1.00 to 2.00
For a visit out of town in consultation, the fee as above for a visit and consultation, with the addition, for every mile except the first, of	1.00 to 2.00
In like manner, for every other service, when out of town, the fee for the service shall first be charged, and for every mile except the first	1.00 to 2.00
For rising in the night† and visit	5.00 to 10.00
For rising in the night and visit in consultation	10.00
For rising in the night and advice at the physician's house	3.00 to 5.00
For advice at the physician's house, according to the importance of the case and the time occupied	1.00 to 10.00
For a letter of advice	5.00 to 10.00
For an opinion involving a question of law, in which a physician may be subpœnaed	10.00 to 50.00
For a post-mortem examination, in a case of legal investigation	20.00 to 50.00
For do. made at the request of the family or relations of the deceased	5.00 to 25.00
For a case of midwifery in the daytime	10.00 to 20.00
For do. if any part of the attendance be in the night	15.00 to 25.00
For capital operations, such as amputations of large limbs, lithotomy, lithotrity, trepanning, extirpation of large tumors, operation for cataract, &c.	50.00 to 200.00
For reducing luxations or fractures of small bones, for stitching recent wounds, opening large abscesses, and similar operations	5.00 to 10.00
For vaccine inoculation	2.00 to 5.00
For re-vaccination	1.00 to 3.00
It is recommended that in all cases of *gonorrhœa* and *syphilis* a retaining fee of from $5.00 to $10.00 be required in advance; the subsequent charges to be made as in ordinary cases of attendance or advice.	

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* If by railroad, from 50 cents to $1 per mile, according to the time saved to the practitioner.

† The night, in this table, is considered as beginning at 10 o'clock, P.M., and ending at 6 o'clock, A.M., or at sunrise when that is later than 6 o'clock, A.M.

There are other distinct charges for minor surgical operations, given in detail, which want of room prevents our printing. We trust our distant readers will not be deluded into supposing that the average collections of physicians here come anywhere near the aggregate which this table makes their charges assume on their books. Far from it. The grand total there recorded may make a very pretty picture, but alas! it is in the main a "dissolving view," the "stuff that dreams are made of," the basis for air castles, chateaux en Espagne. If our fee list is any aid to our correspondent as a chart to steer by, he is welcome to it; we hope it may help him. We confess that he has awakened in us something of the curiosity which he acknowledges. We should be glad to see in the journals of other places copies of their local fee lists.

The following case illustrates the reparatory power of nature, and suggests a due degree of caution in the treatment of injuries involving the question of amputation.

MESSRS. EDITORS,—I examined, a few days since, the arm of John Sheen, a young Irishman, 19 years old, who, when he was 10 years old, had his left arm jammed between two railroad cars, within about four inches of his shoulder. More than two inches of the entire shaft of the humerus are gone at the seat of the injury. The muscles of the anterior and exterior sides of the limb appear to have been cut off by the accident. The muscles of the posterior, part of the interior, and very little of the exterior, are apparently serviceable. There are two long scars at the point of injury, one of them anterior and the other exterior. The arm is very much smaller at this point than anywhere else, but is nearly as long, large and fat as the other arm. The patient is quite fleshy. He can carry his arm backward, forward, and upward to his face rapidly, and his hand is quite strong. All below the injury is apparently as good as in the other arm. He cannot straighten out his arm, of course, for the want of bone and muscles anteriorly. The arm hangs dangling by his side, and yet is *very* useful. Numerous pieces of bone came away at the point of injury. He can put on and take off his coat as quickly as any one. When his coat is on, you see a slight projection of the upper part of the humerus.

The surgeons in Boston, where the accident occurred, who saw it, wished to amputate the arm, but his mother would not permit it to be done, and the result is a *very useful* arm. Judging from its appearance now, at the seat of the injury, I think no surgeon would have hesitated to advise amputation at the time of the accident, and yet it was a *very fortunate* thing for the patient that amputation was not permitted. This case may afford a useful hint to our army surgeons.

Portsmouth, N. H., Nov. 15th, 1861. N. L. FOLSOM, M.D.

MESSRS. EDITORS,—I am glad to see the charge of dishonesty and untruthfulness made against the New American Cyclopœdia in reference to the Monthyon prize, retracted by W. E. C. He, however, has committed another mistake about as bad, in supposing that the work of Dr. Rice was relied upon at all in the matter. While this work is referred to, and very properly, in points of fact which have become matters of history in regard to the ether controversy, any one will see, by referring to the article ANÆSTHETICS, in Vol. I., p. 506 (*corrected edition*), that the Cyclopœdia expressly states that the Monthyon prize was awarded to Dr. Morton for "introducing ether into practice after the indications of Dr. Jackson."

Boston, November, 1861. S. K., JR.

MASSACHUSETTS MEDICAL BENEVOLENT ASSOCIATION.—The members of this association held their annual meeting at their rooms in Temple Place on the 31st ult. In the absence of the President, Dr. John Homans, of this city, presided. The record of the Association for the past year was read by the Secretary, Dr. J. N. Borland, and accepted. The Treasurer, Dr. Francis Minot, reported that he had received during the past year, chiefly from assessments, the sum of $128, and interest amounting to $68.05. The balance from last year's account was $1,801.38. The whole amounting to $1,997.43. The amount expended was 9.66, leaving a balance of $1,987.77, which is chiefly invested in the Savings Banks—$99 being in the U. S. Treasury Notes, and $23.08 in cash, in the hands of the Treasurer.

The following gentlemen were chosen officers for the ensuing year:—Dr. Geo. Hayward, *President;* Dr. Aug. A. Gould, *Vice President;* Dr. J. N. Borland, *Secretary;* Dr. Francis Minot, *Treasurer.* Drs. Geo. H. Lyman, Wm. J. Dale, John Homans, George Hayward, Jr., and R. W. Hooper, of Boston, W. W. Wellington, of Cambridgeport, Anson Hooker, of East Cambridge, P. M. Crane, of East Boston, and B. E. Cotting, of Roxbury, were appointed *Trustees.*

NAVAL APPOINTMENTS FROM MASSACHUSETTS.—Of the forty new Assistant Surgeons required for the Navy, thirteen have been appointed from Massachusetts. The following are their names:—R. T. Edes, Chas. E. Stedman, H. M. Wells, W. C. Lyman, I. H. Hazelton, G. T. Shipley, Charles H. Perry, C. T. Hubbard, Edgar Holden, B. H. Kidder, J. H. Macomber, Samuel W. Abbott, Samuel N. Brayton.

MEDICAL INSTITUTION AT GUADALAJARA, MEXICO.—Dr. Carman, formerly Prof. of Materia Medica in the Medical Department of the University of the Pacific, now practising medicine at Mazatlan, furnishes to *The San Francisco Medical Press* an account of the Medical Institution located Guadalajara, Mexico, from which we reprint the following:—

"The school has seven professors, natives of Mexico, five of whom are graduates of the Parisian School of Medicine; the Faculty is composed of men of superior intelligence, and are capable of reflecting credit on their profession in any part of the world. The college building is a stately edifice, and in connection with it there is one of the most extensive hospitals on this continent. It is large and well ventilated, and capable of accommodating, in a comfortable manner, near 3000 patients. There are some 500 sick, at present, in the hospital, and everything is finely arranged for the benefit of the patients, every department bearing the marks of perfect order and system; so much so, that a visit to the institution is in the highest degree gratifying to the medical man. The hospital building was erected during the latter part of the last century by the Spaniards, but recently it has been renovated and enlarged, and greatly improved in its internal arrangement. It is in charge of Dr. Pablo Gutierrez, together with Drs. Rafael Jimenes Castro and Ramon Ochoa. Dr. Pablo Gutierrez is Surgeon-in-Chief."

VITAL STATISTICS OF BOSTON.

FOR THE WEEK ENDING SATURDAY, NOVEMBER 16th, 1861.

DEATHS.

	Males.	*Females*	*Total*
Deaths during the week,	32	30	62
Average Mortality of the corresponding weeks of the ten years, 1851–1861,	34.5	34.0	68.5
Average corrected to increased population,	..	..	76.36
Deaths of persons above 90,	..	..	..

Mortality from Prevailing Diseases.

Phthisis.	Chol. Inf.	Croup.	Scar. Fev.	Pneumonia.	Variola.	Dysentery.	Typ. Fev.	Diphtheria.
12	0	3	2	3	0	0	2	0

METEOROLOGY.

From Observations taken at the Observatory of Harvard College —For the week ending Nov. 9th.

Mean height of Barometer,	29 696	Highest point of Thermometer,	61.0
Highest point of Barometer,	30.194	Lowest point of Thermometer,	35.0
Lowest point of Barometer,	29.476	General direction of Wind,	W.N.W.
Mean Temperature,	47.2	Am't of Rain (in inches)	1.37

DEATHS IN BOSTON for the week ending Saturday noon, November 16th, 62. Males, 32—Females, 30.—Accidents, 2—anæmia, 1—inflammation of the bowels, 1—disease of the brain, 1—inflammation of the brain, 1—consumption, 12—convulsions, 5—croup, 3—dropsy of the brain, 1—scarlet fever, 2—typhoid fever, 2—gastritis, 2—hæmorrhage, 1—disease of the heart, 1—infantile disease, 3—intemperance, 2—disease of the kidneys, 2—disease of the liver, 1—congestion of the lungs, 1—inflammation of the lungs, 3—old age, 4—puerperal disease, 1—suicide, 1—ulcer (of stomach), 1—unknown, 2—whooping cough, 6.

Under 5 years of age, 23—between 5 and 20 years, 3—between 20 and 40 years, 17—between 40 and 60 years, 9—above 60 years, 10. Born in the United States, 37—Ireland, 20—other places, 5.